Aggregate payments for excess readmissions is, for a hospital for the applicable period, the sum, for the applicable conditions, of the product for each applicable condition of:

(1) The base operating DRG payment amount for the hospital for the applicable period for such condition;

(2) The number of admissions for such condition for the hospital for the applicable period; and

(3) The excess readmission ratio for the hospital for the applicable period minus 1.

Applicable condition is a condition or procedure selected by the Secretary among conditions and procedures for which:

(1) Readmissions represent conditions or procedures that are high volume or high expenditures; and

(2) Measures of such readmissions have been endorsed by the entity with a contract under section 1890 and such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

Applicable hospital is a hospital described in section 1886(d)(1)(B) of the Act or a hospital in Maryland that is paid under section 1814(b)(3) of the Act and that, absent the waiver specified by section 1814(b)(3) of the Act, would have been paid under the hospital inpatient prospective payment system.

Applicable period is, with respect to a fiscal year, the 3-year period (specified by the Secretary) from which data are collected in order to calculate excess readmission ratios and adjustments under the Hospital Readmissions Reduction Program.

Base operating DRG payment amount is the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount is determined without regard to any payment adjustments under the Hospital Value-Based Purchasing Program, as specified under § 412.162. This amount does not include any additional payments for indirect medical education under § 412.105, the treatment of a disproportionate share of low-income patients under § 412.106, outliers under subpart F of this part, and a low volume of discharges under § 412.101.

Excess readmissions ratio is a hospital-specific ratio for each applicable condition for an applicable period, which is the ratio (but not less than 1.0) of risk-adjusted readmissions based on actual readmissions for an applicable hospital for each applicable condition to the risk-adjusted expected readmissions for the applicable hospital for the applicable condition.

Floor adjustment factor is the value that the readmissions adjustment factor cannot be less than for a given fiscal year. The floor adjustment factor is set at 0.99 for FY 2013, 0.98 for FY 2014, and 0.97 for FY 2015 and subsequent fiscal years.

Readmission is the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period of 30 days from the date of such discharge.

Readmissions adjustment factor is equal to the greater of:

(1) 1 minus the ratio of the aggregate payments for excess readmissions to aggregate payments for all discharges; or

(2) The floor adjustment factor.

Wage-adjusted DRG operating payment is the applicable average standardized amount adjusted for resource utilization by the applicable MS–DRG relative weight and adjusted for differences in geographic costs by the applicable area wage index (and by the applicable cost-of-living adjustment for hospitals located in Alaska and Hawaii). This amount includes an applicable payment adjustment for transfers under § 412.4(f).

§ 412.154 Payment adjustments under the Hospital Readmissions Reduction Program.

(a) *Scope.* This section sets forth the requirements for determining the payment adjustments under the Hospital Readmissions Reduction Program for applicable hospitals to account for excess readmissions in the hospital.

(b) *Payment adjustment.* (1) *General.* To account for excess readmissions, except as provided for in paragraph (d) of this section, an applicable hospital's

base operating DRG payment amount is adjusted for each discharge occurring during the fiscal year. The payment adjustment for each discharge is determined by subtracting the product of the base operating DRG payment amount (as defined in §412.152) for such discharge by the hospital's readmission payment adjustment factor for the fiscal year (determined under paragraph (c) of this section) from the base operating DRG payment amount for such discharge.

(2) *Special treatment for sole community hospitals.* In the case of a sole community hospital that receives payments under §412.92(d) based on the hospital-specific rate, the difference between the hospital-specific rate payment and the Federal rate payment determined under subpart D of this part is not affected by this payment adjustment.

(c) *Methodology to calculate the readmissions payment adjustment factor.* A hospital's readmissions payment adjustment factor is the higher of the ratio described in paragraph (c)(1) of this section or the floor adjustment factor set forth in paragraph (c)(2) of this section.

(1) *Ratio.* The ratio is equal to 1 minus the ratio of the aggregate payments for excess readmissions as defined in §412.152 and the aggregate payments for all discharges as defined in §412.152.

(2) *Floor adjustment factor.* The floor adjustment factor is:

(i) For FY 2013, 0.99;

(ii) For FY 2014, 0.98; and

(iii) For FY 2015 and subsequent fiscal years, 0.97.

(d) *Hospitals paid under section 1814(b)(3) of the Act (certain Maryland hospitals).* The Secretary will consider whether to exempt Maryland hospitals that are paid under section 1814(b)(3) of the Act and that, absent the provisions of section 1814(b)(3) of the Act, would be paid under section 1886(d) of the Act from the Hospital Readmissions Reduction Program, provided that the State submits an annual report to the Secretary describing how a similar program to reduce hospital readmissions in that State achieves or surpasses the measured results in terms of health outcomes and cost savings for the Hospital Readmissions Reduction Program as applied to hospitals described in section 1886(d)(1)(B) of the Act.

(1) CMS will establish criteria for evaluation of Maryland's annual report to the Secretary to determine whether Maryland will be exempted from the program for a given fiscal year.

(2) Maryland's annual report to the Secretary and request for exemption from the Hospital Readmissions Reduction Program must be resubmitted and reconsidered annually.

(e) *Limitations on review.* There is no administrative or judicial review under this subpart of the following:

(1) The determination of base operating DRG payment amounts.

(2) The methodology for determining the adjustment factor under paragraph (c) of this section, including the excess readmissions ratio, aggregate payments for excess readmissions, and aggregate payments for all discharges.

(3) The applicable period.

(4) The applicable conditions.

(f) *Reporting of hospital-specific information.* CMS will make information available to the public regarding readmissions rates of each applicable hospital (as defined in §412.152) under the Hospital Readmissions Reduction Program.

(1) To ensure that an applicable hospital has the opportunity to review and submit corrections for its excess readmission ratios for the applicable conditions for a fiscal year that are used to determine its readmissions payment adjustment factor under paragraph (c) of this section, CMS will provide each applicable hospital with confidential hospital-specific reports and discharge level information used in the calculation of its excess readmission ratios.

(2) Applicable hospitals will have a period of 30 days after receipt of the information provided in paragraph (f)(1) of this section to review and submit corrections for the excess readmission ratios for each applicable condition that are used to calculate the readmissions payment adjustment factor under paragraph (c) of this section for the fiscal year.

(3) The administrative claims data used to calculate an applicable hospital's excess readmission ratios for the applicable conditions for a fiscal

year are not subject to review and correction under paragraph (f)(1) of this section.

(4) CMS will post the excess readmission ratios for the applicable conditions for a fiscal year for each applicable hospital on the *Hospital Compare* Web site.

§§ 412.155–412.159 [Reserved]

INCENTIVE PAYMENTS UNDER THE HOSPITAL VALUE-BASED PURCHASING PROGRAM

§ 412.160 Definitions for the Hospital Value-Based Purchasing (VBP) Program.

As used in this section and in §§ 412.161 through 412.167:

Achievement threshold (or achievement performance standard) means the median (50th percentile) of hospital performance on a measure during a baseline period with respect to a fiscal year.

Applicable percent means the following:

(1) For FY 2013, 1.0 percent;

(2) For FY 2014, 1.25 percent;

(3) For FY 2015, 1.50 percent;

(4) For FY 2016, 1.75 percent; and

(5) For FY 2017 and subsequent fiscal years, 2.0 percent.

Base operating DRG payment amount means the following:

(1) With respect to a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Act), the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount is determined without regard to any payment adjustments under the Hospital Readmissions Reduction Program, as specified under § 412.154. This amount does not include any additional payments for indirect medical education under § 412.105, the treatment of a disproportionate share of low-income patients under § 412.106, outliers under subpart F of this part, or a low volume of discharges under § 412.101.

(2) With respect to a Medicare-dependent, small rural hospital that receives payments under § 412.108(c) or a sole community hospital that receives payments under § 412.92(d), the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount does not include any additional payments for indirect medical education under § 412.105, the treatment of a disproportionate share of low-income patients under § 412.106, outliers under subpart F of this part, or a low volume of discharges under § 412.101. This amount also does not include the difference between the hospital-specific payment rate and the Federal payment rate determined under subpart D of this part.

(3) With respect to a hospital that is paid under section 1814(b)(3) of the Act, the payment amount under section 1814(b)(3) of the Act.

Benchmark means the arithmetic mean of the top decile of hospital performance on a measure during the baseline period with respect to a fiscal year.

Cited for deficiencies that pose immediate jeopardy means that, during the applicable performance period, the Secretary cited the hospital for immediate jeopardy on at least two surveys using the Form CMS–2567, Statement of Deficiencies and Plan of Correction.

Domain means a grouping of measures used for purposes of calculating the Total Performance Score for each hospital with respect to a fiscal year.

Domain score means the total number of points awarded to a hospital for a domain.

Hospital means a hospital described in section 1886(d)(1)(B) of the Act, but does not include a hospital, with respect to a fiscal year, for which one or more of the following applies:

(1) The hospital is subject to the payment reduction under section 1886(b)(3)(B)(viii)(I) of the Act for the fiscal year;

(2) The Secretary cited the hospital for deficiencies that pose immediate jeopardy to the health or safety of patients during the performance period that applies with respect to the fiscal year;

(3) There are not a minimum number of measures that apply to the hospital for the performance period for the fiscal year; or

(4) There are not a minimum number of cases for the measures that apply to